FBMC
BENEFITS MANAGEMENT
P.O. Box 1878, Tallahassee, FL 32302-1878

Attention
Mailslot 37

2017 SPECIAL ENROLLMENT
Plan Year 2017
July 1, 2016 - June 30, 2017

STATE OF WEST VIRGINIA
Mountaineer Flexible Benefits

1 INSTRUCTIONS

DURING THE 2017 SPECIAL ENROLLMENT RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN JULY 15, 2016.

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?
- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage of other benefits
- **EXISTING BENEFITS NOT INDICATED ON THIS FORM WILL CONTINUE AS CURRENTLY ENROLLED.**

HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:
- IMPORTANT: If you want to add, change or cancel coverage, **you must check the box beside the appropriate benefit** in Section 3. Indicate coverage levels and any other pertinent information.
- If you select family coverage for any benefit, you must provide dependent information in Section 4.

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SOCIAL SECURITY #	E-MAIL	TYPE OF FORM
		☒ 2017 SPECIAL ENROLLMENT

LAST NAME	FIRST NAME	MI

HOME ADDRESS [STREET]	CITY	STATE	ZIP	HOME PHONE

BIRTH DATE			DATE EMPLOYED	EFFECTIVE DATE	OFFICE PHONE
/ /	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	/ /	7/1/16	

3 Mountaineer Flexible Benefits Tax-Free Benefits Paid by Employees

IF YOU ENROLL IN A HEALTH SAVINGS ACCOUNT, YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT, BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT.

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS			COST PER PAY PERIOD
☐	☐	☐	☐	**DELTA DENTAL** ☐ Routine ☐ Assistance ☐ Basic ☐ Enhanced	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family	If you select dependent coverage for dental, vision or hearing, you must complete the dependent information below.	
☐	☐	☐	☐	**VISION** CHOOSE ONE VISION OPTION: ☐ Exam Plus ☐ Full Service	☐ Employee Only ☐ Employee & Family		
☐	☐	☐	☐	**EPIC HEARING SERVICE PLAN**	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family		
☐	☐	☐	☐	**LONG-TERM DISABILITY INCOME PLAN** Employee Only	☐ 50% of salary coverage ☐ 70% of salary coverage		
☐	☐	☐	☐	**SHORT-TERM DISABILITY INCOME PLAN** Employee Only			
☐	☐	☐	☐	**MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT** Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2017.			
☐	☐	☐	☐	**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT** Use cost per-pay-period from your Worksheet. ☐ Married, filing separately ☐ Married, filing jointly ☐ Single, head of household ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2017.			
☐	☐		☐	**LEGAL (POST-TAX)**			

HEALTH SAVINGS ACCOUNT* (Additional forms required.)

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE
☐	☐	☐	☐

Select your HSA coverage type:
- ☐ Individual ($3,350 maximum 2017 PY)
- ☐ Family ($6,750 maximum 2017 PY)
- ☐ Over 55 Catch-up (additional maximum $1,000)

*** Must be enrolled in PEIA Plan C effective 7/1/16.**

Box #1 2017 Plan Year Total Dollar Amount		
Box #2 Number of Pay Periods	÷	
Box #3 Reduction Per Regular Pay Period	=	

LIMITED-USE MEDICAL EXPENSE FSA*

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE
☐	☐	☐	☐

*** Must be enrolled in PEIA Plan C and also HSA effective 7/1/16.**

Box #1 2017 Plan Year Total Dollar Amount		**SUBTOTAL**	
Box #2 Number of Pay Periods	÷	**HSA**	
Box #3 Reduction Per Regular Pay Period	=	**Limited-Use Medical Expense FSA**	
		SUBTOTAL	
		TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD	

4 DEPENDENT INFORMATION USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	Male/ Female	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED			
					DENTAL	VISION	HEARING	LEGAL
	SPOUSE							

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

FOR THE 2017 SPECIAL ENROLLMENT TURN COMPLETED FORMS INTO YOUR BENEFITS COORDINATOR NO LATER THAN JULY 15, 2016.

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

FEIN# _____

AGENCY NAME _____

4 DIGIT WORK LOCATION # _____ EFFECTIVE DATE 7/1/16

NO. PAY DEDUCTIONS _____

GROSS ANNUAL SALARY _____

BENEFIT COORDINATOR SIGNATURE _____

BENEFIT COORDINATOR PHONE# ( ) _____

BENEFIT COORDINATOR FAX# ( ) _____

LOCATION TYPE: ☐ STATE AGENCIES ☐ UNIVERSITIES & COLLEGES ☐ COUNTY BOARDS OF EDUCATION

ENROLLMENT FORMS MUST BE MAILED TO FBMC AND POSTMARKED BY JULY 20, 2016.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED